# MULTIDISCIPLINARY TEAM - ADDITIONAL INFORMATION FORM

**6 years to 11 years 11 months**
*(adapted from the HSE children's services referral form)*

*** To be completed by the family along with the Service Request Form – Child ***

| **Individual Information** | | |
|---|---|---|
| **Surname:** | **First Name:** | **DOB:** |
| **Referrer Information** | | |
| **Name of Referrer:** | | **Date:** |

**Your child's Development** (Please note some questions may not be relevant your child)

**1. Movement (Gross Motor Skills)**

| Has he/she achieved the following? | Yes | No | Not Sure | If yes at what age: |
|---|---|---|---|---|
| Walking Independently: | ☐ | ☐ | ☐ | |
| Running: | ☐ | ☐ | ☐ | |
| Jumping: | ☐ | ☐ | ☐ | |
| Does he/she take part in active games? | ☐ | ☐ | ☐ | |

**Please describe:**

| Do any of the following describe your child's movements? | Yes | No | Not Sure |
|---|---|---|---|
| Trips a lot: | ☐ | ☐ | ☐ |
| Falls a lot: | ☐ | ☐ | ☐ |
| Tires easily: | ☐ | ☐ | ☐ |
| Bumps into other things a lot: | ☐ | ☐ | ☐ |
| Always on the go: | ☐ | ☐ | ☐ |
| Have you any concerns about your child's posture? | ☐ | ☐ | ☐ |

**If yes, please describe:**

| | | | |
|---|---|---|---|
| Does he/she have mobility aids? | ☐ | ☐ | ☐ |

**If Yes, please describe:**

**2. Hand Movement and Fine Motor Skills**

| Which of the following can your child do? | Yes | No | Not Sure |
|---|---|---|---|
| Pick up small objects such as raisins or beads: | ☐ | ☐ | ☐ |
| Play with construction games (e.g. building blocks/lego) | ☐ | ☐ | ☐ |
| Use a pencil or pen: | ☐ | ☐ | ☐ |
| Use a scissors: | ☐ | ☐ | ☐ |

**3. Sensory Processing**

| | | | |
|---|---|---|---|
| Is your child either unusually sensitive or does not notice: noise, touch, texture, movement, smell or taste? | Yes☐ | No☐ | Not Sure☐ |

**If yes, please give details:**

## 4. Daily Living Skills

**Describe any other concerns you have about your child's daily activities?**

## 4A. Eating, Drinking and Swallowing

**Can your child do the following?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Use a cup?** | Yes☐ | No☐ | Not Sure☐ | **Use a spoon?** | Yes☐ | No☐ | Not Sure☐ |
| **Use a fork?** | Yes☐ | No☐ | Not Sure☐ | **Use a knife?** | Yes☐ | No☐ | Not Sure☐ |
| **Does your child have feeding difficulties?** | Yes☐ | No☐ | | **Does your child have special feeding requirements?** | Yes☐ | No☐ | |
| **If yes, please describe the feeding difficulty/special feeding requirements?** | | | | | | | |
| **Is your child on oral nutrition supplements?** | Yes☐ | No☐ | | **Please specify:** | | | |

## 4B. Urinary and Bowel Habits (Continence)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Is your child toilet trained by day?** | Yes☐ | No☐ | At what age? | **Is your child toilet trained by night?** | Yes☐ | No☐ | At what age? |
| **Has he/she any special urine problems? (e.g. catheter)** | | | | Yes☐ | No☐ | Not Sure☐ | |
| **Has your child any bowel problems? e.g. Constipation or diarrhoea:** | | | | Yes☐ | No☐ | Constipation☐ | Diarrhoea☐ |
| **If yes to either of the above, please describe problems, and what helps to prevent it?** | | | | | | | |
| **Does your child wear pads?** | | | | Yes☐ | No☐ | Sometimes ☐ | |

## 4C. Personal Care, Dressing and Independence

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Does your child dress independently?** | Yes☐ | No☐ | Not Sure☐ | **Does your child undress independently?** | Yes☐ | No☐ | Not Sure☐ |
| **Does your child wash independently?** | | | | Yes☐ | No☐ | Not Sure ☐ | |
| **If no to any of the above, please describe your concerns?** | | | | | | | |
| **Do you have any concerns about your child's self-care skills? (e.g. organising belongings, managing routines etc.)** | | | | Yes☐ | No☐ | Not Sure☐ | |
| **If yes, please describe?** | | | | | | | |
| **Have you any concerns about your child's safety awareness in the home/community? (e.g. hot surfaces/open traffic etc.)** | | | | Yes☐ | No☐ | Not Sure☐ | |
| **If yes, please describe:** | | | | | | | |

| 4D. Sleep and Rest | | | |
|---|---|---|---|
| **Do you have concerns for your child's sleep or ability to relax?** | Yes☐ | No☐ | Not Sure☐ |
| **Does your child have difficulty initiating activities or appear lethargic or tire easily?** | Yes☐ | No☐ | Not Sure☐ |
| **If yes, please describe:** | | | |
| **Does your child need any specialised equipment to aid a restful sleep?** | Yes☐ | No☐ | Not Sure☐ |
| **Please give details:** | | | |

| 4E. Breathing | | | |
|---|---|---|---|
| **Does your child experience respiratory difficulties?** | Yes☐ | No☐ | **And use any of the following?**<br>Nebulise☐ Home Oxygen☐<br>CPAP/Ventilation☐ Other☐ |
| **Please give details:** | | | |

| 5. Communication, Speech and Language | | | |
|---|---|---|---|
| **How does your child express himself/herself? (e.g. words, gestures, actions, picture exchange and signs, adapted communication devices)** | | | |
| **Do you have any concerns about your child's ability to communicate?** | Yes☐ | No☐ | Not Sure☐ |
| **If yes, please describe:** | | | |
| **Do any of the following describe your child?** | | | |
| **My child has difficulty telling a story (e.g. telling me about school)** | Yes☐ | No☐ | Not Sure☐ |
| **My child gets confused when I give him/her long instructions:** | Yes☐ | No☐ | Not Sure☐ |
| **My child has difficulty expressing himself/herself (e.g. the amount of words my child can say)** | Yes☐ | No☐ | Not Sure☐ |
| **My child's speech is difficult to understand compared to other children:** | Yes☐ | No☐ | Not Sure☐ |
| **If yes to any of the above, please give further details:** | | | |
| **Does your child use any augmentative or alternative communication supports (e.g. Visuals, Lámh, Device)** | Yes☐ | No☐ | Not Sure☐ |
| **If yes, please give details:** | | | |

| **6. Behaviour and Emotions (**Attach copies of any relevant reports and information) | | | |
|---|---|---|---|
| **Have you concerns about your child's behaviour?** | Yes☐ | No☐ | Not Sure☐ |
| **Is your child's behaviour difficult to manage at home?** | Yes☐ | No☐ | Not Sure☐ |
| **Please describe:** | | | |
| **Is your child's behaviour difficult to manage at school?** | Yes☐ | No☐ | Not Sure☐ |
| **Please describe:** | | | |

| **Do the following statements describe your child? (Please tick the appropriate boxes)** | | | | |
|---|---|---|---|---|
| **Frequent tantrums** ☐ | **Aggressive** ☐ | **Irritable/Frustrated** ☐ | **Excessive Crying** ☐ | **Clingy** ☐ |
| **Upset for minor things** ☐ | **Withdrawn/ too quiet** ☐ | **Doesn't like change** ☐ | **Over-reactive** ☐ | **Worries a lot** ☐ |
| **Upsetting language towards others** ☐ | **Obsessional behaviours/ Interests** ☐ | **Rapid Mood Swings** ☐ | **Will not comply with activities necessary for their health and wellbeing** ☐ | |
| **Please give any further comment of your child's behaviour and emotions:** | | | | |

| **7. Social Interaction and Relationships, Play and Leisure** | | |
|---|---|---|
| **How does your child like to play? (You may tick more than one box)** | **Alone** ☐ | **Next to other children but not with them** ☐ |
| | **With other children** ☐ | **With other adults** ☐ |

| | | | |
|---|---|---|---|
| **Do you have concerns about your child's ability to form relationships with you and others?** | Yes☐ | No☐ | Not Sure☐ |
| **If yes, please give details:** | | | |

| | |
|---|---|
| **What activities does your child like doing?** | **Please describe:** |
| **What play or social activities does your child join in the community?** | **Please describe:** |
| **What extra help does your child need to play with others?** | **Please describe:** |
| **Please give further comments about your child's play, friendship and peer activities?** | |

| **8. Learning and School** | | | | |
|---|---|---|---|---|
| **Do you have any concerns about your child's ability to concentrate?** | Yes☐ | No☐ | Not Sure☐ | |
| **How would you describe your child's overall situation at school?** | **Good** ☐ | **Mostly doing ok** ☐ | **Some problems** ☐ | **Major problems** ☐ |
| **If yes, or there are problems, please give details of your concerns including previous assessments:** | | | | |

| 9. Eyesight and Hearing | | | |
|---|---|---|---|
| **Have you concerns about your child's eyesight?** | Yes☐ | No☐ | Not sure☐ |
| **If yes, please describe level of visual impairment:** | | | |
| **Name of teacher for visually impaired (if relevant):** | | | |
| **Have you concerns about your child's hearing?** | Yes☐ | No☐ | Not sure☐ |
| **If yes please describe level of hearing impairment:** | | | |
| **Name of teacher for the hearing impaired (if relevant):** | | | |

| 10. Pain | | | |
|---|---|---|---|
| **Does your child experience any pain during movements? (e.g. rolling, crawling, walking)** | Yes☐ | No☐ | Not sure☐ |
| **If yes, please give details:** | | | |

| 11. Additional Information |
|---|
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